Child Fatality Report Release of Information to the Public

Person ID: 84577639

County of Child's Residence: MCLENNAN

Gender: Male

Age: 8 Year(s) 1 Month(s)

Date of Death: 08/03/2022

On the date of the fatality, the child was not in DFPS conservatorship and was living with the child's parent, a managing conservator, a legal guardian or other person entititled to the child's possession.

Child's Name: Daniels,Tyler P

Current Report(s) of Abuse/Neglect:

Intake Date(s): 08/01/2022

Summary of Allegation(s)/Investigation:

The Department received a report that law enforcement responded to a home where a child was found unresponsive for an unknown amount of time. The deceased child was found not breathing. The deceased child was transported to an emergency room where he was placed on a ventilator. It was unknown who the deceased child was with at home. The deceased child's asthma is poorly controlled, per healthcare professional. The medical charts revealed a lot of missed appointments for asthma and the Pulmonologist. It is unknown why appointments were missed. The deceased child has had Child Protective Services reports due to noncompliance with appointments for asthma.

The Department's investigation determined that the deceased child's mother was giving the deceased child too much albuterol during breathing treatments. The pharmacist confirmed that he had not had any refills for his inhalers and albuterol, which were needed daily. Pediatrician confirmed that the deceased child had over 30-missed appointments to follow up with specialists and pediatricians in regard to his Asthma. The deceased child's mother voiced that the deceased child was allergic to a lot of things and was supposed to get allergy shots weekly, however, she stopped taking him a year ago. She stated she missed his appointments because she did not have transportation. She admitted she was aware of Medicaid transportation but never utilized it. The mother could not show caseworker the deceased child's daily inhalers. She admitted he would get two vials of albuterol every two hours which was too much. Doctor confirmed that if the deceased child was not given his medication as directed and was given too much

albuterol, it would lead to death.

The Medical Examiner completed an autopsy. At the time of DFPS case closure, the final autopsy had not been received.

A law enforcement investigation remains active and ongoing at case closure.

Investigation Findings:

The Department confirmed allegations that the deceased child's mother committed medical neglect of the deceased child, which led to the child's death. The deceased child's mother did not have the proper medication to help treat the deceased child's Asthma. He was being given too much albuterol during breathing treatments which doctor indicated could lead to death. The mother also missed over 30 medical appointments for the deceased and did not have his daily medications. The deceased was supposed to have allergy shots weekly but the mother had stopped taking him over a year ago.

Safety and Risk Assessment Factors Identified:
08/01/2022: Structured Decision Making Safety Assessment - Initial Safe
Structured Decision Making Risk Assessment Final Level: High

Safety and Risk Assessment Factors Identified:

Case Action:

Family Preservation

Services and Referrals Provided to the Family:

Counseling and Evaluation,Parent/Caregiver Training,Basic Needs Support

Other Services:

Not Applicable

Other Actions Taken to Mitigate Risk:

Family is receiving services through Family-Based Safety Services

If one or more children were previously removed from the home, for each conservatorship episode, summarize dates of conservatorship and type of placement at the end of conservatorship:

Not Applicable

Previous Report of Abuse/Neglect:

Intake Date(s): 02/03/2020

Summary of Previous Allegation(s)/Investigation:

The Department received a report that the deceased child's mother and the deceased child's mother's paramour were using cocaine and marijuana around the deceased child and the deceased child's siblings. The report had concerns that the children did not have beds and had bumps from insect bites or bedbugs.

The Department determined the deceased child's mother and mother's paramour were negative on drug tests. No bugs were observed in the home and no outcries were made by the verbal children. No additional services were offered to the family.

Investigation Findings:

The Department did not confirm allegations of neglectful supervision of the deceased child or the deceased child's siblings by the deceased child's mother and deceased child's mother's paramour.

Safety and Risk Assessment Factors Identified:
02/05/2020: Structured Decision Making Safety Assessment - Initial Safe
Structured Decision Making Risk Assessment Final Level: Moderate

Safety and Risk Assessment Factors Identified:

Case Action:

Close

Services and Referrals Provided to the Family:

Counseling and Evaluation,Parent/Caregiver Training

Other Services:

Not Applicable

Other Actions Taken to Mitigate Risk:

Not Applicable

Previous Report of Abuse/Neglect:

Intake Date(s): 01/24/2020, 02/03/2020

Summary of Previous Allegation(s)/Investigation:

The Department received a report that the deceased child was given his nebulizer medication at school because he was wheezing. He continued to wheeze 2 hours later. He cannot have his nebulizer for 4 hours, so they tried to call the deceased child's mother. The deceased child's mother's phone wasn't working so they called the deceased child's aunt, who the deceased child's mother was found to be with. The school reported

the deceased child's heart rate was fast, his hands were shaking and clammy. After an hour and half of waiting for the deceased child's mother to arrive at the school, the school called for an ambulance. This is the second time the school has had to call for an ambulance. A second intake was received alleging the deceased child's mother and the deceased child's mother's paramour smoke marijuana and cocaine while the children are in the room with them. The report had concerns that the children did not have beds and had bumps from insect bites or bedbugs.

The Department's investigation determined that medical staff did not have concerns for mother's ability to care for the deceased child. The deceased child indicated he was getting his medication daily. The deceased child's mother and mother's paramour were negative on drug tests. No bugs were observed in the home and no outcries were made by the verbal children. No additional services were offered to the family.

Investigation Findings:

The Department did not confirm allegations of neglectful supervision of the deceased child, or the deceased child's siblings by the deceased child's mother and deceased child's mother's paramour. The deceased child's mother tested negative for all substances on her drug tests and denied any bugs in the home. No bugs were observed in the home and no outcries were made by the verbal children.

The Department did not confirm allegations of medical neglect of the deceased child by the deceased child's mother. The deceased child indicated he was getting his medication daily. Medical staff did not have concerns for mother's care of the deceased child.

Safety and Risk Assessment Factors Identified:
01/24/2020: Structured Decision Making Safety Assessment - Initial Safe
Structured Decision Making Risk Assessment Final Level: Moderate

Safety and Risk Assessment Factors Identified:

Case Action:

Close

Services and Referrals Provided to the Family:

Counseling and Evaluation,Parent/Caregiver Training

Other Services:

Not Applicable

Other Actions Taken to Mitigate Risk:

Not applicable

Previous Report of Abuse/Neglect:

Intake Date(s): 08/12/2021

Summary of Previous Allegation(s)/Investigation:

The Department received a report that the deceased child's mother was observed to have slapped the deceased child and hit the deceased child's sibling forcefully on the head with a cell phone. There was a bump noticed on the deceased child's head and the mother did not respond when she was asked how he got the bump.

The Department determined the deceased child denied being hit by his mother. The verbal siblings made no

outcry of physical abuse by mother. No additional services were offered to the family.

Investigation Findings:

The department did not confirm allegations of physical abuse of the deceased child by the deceased child's mother. The deceased child denied being hit and did not remember how he got the injury. The mother indicated she has never hit her children with a phone. No additional services were offered to the family.

Safety and Risk Assessment Factors Identified:
08/13/2021: Structured Decision Making Safety Assessment - Initial Safe
Structured Decision Making Risk Assessment Final Level: Moderate

Safety and Risk Assessment Factors Identified:

Case Action:

Close

Services and Referrals Provided to the Family:

Other Services:

Not Applicable

Other Actions Taken to Mitigate Risk:

Not Applicable

Previous Report of Abuse/Neglect:

Intake Date(s): 04/06/2022

Summary of Previous Allegation(s)/Investigation:

The Department received a report that the deceased child's mother has failed to show for 32 appointments with primary care, specialist, and imaging over the past 6 years with the deceased child. The mother has allowed his medication to run out. This has resulted in multiple unnecessary hospitalizations.

The investigation determined that the deceased child had no-showed and failed to follow-up with numerous appointments, but he did have his medications. The school reports the deceased child always has his medication at school. During the investigation he was seen by a medical professional. The deceased child's mother scheduled needed appointments.

Investigation Findings:

The Department did not confirm the allegations of medical neglect of the deceased child by the deceased child's mother. Although numerous appointments had been missed, it appeared the deceased child was receiving needed medications.

Safety and Risk Assessment Factors Identified:
05/19/2022: Structured Decision Making Safety Assessment - Initial Safe
Structured Decision Making Risk Assessment Final Level: Moderate

Safety and Risk Assessment Factors Identified:

Case Action:

Close

Services and Referrals Provided to the Family:

Basic Needs Support

Other Services:

Not Applicable

Other Actions Taken to Mitigate Risk:

Not Applicable

Other Previous Report of Abuse/Neglect:

Intake Date(s):

Summary of Previous Allegation(s)/Investigation:

Investigation Findings:

Safety and Risk Assessment Factors Identified:

Case Action:

Services and Referrals Provided to the Family:

Other Services:

Other Actions Taken to Mitigate Risk:

Note: This report was prepared on 02/24/2023 and does not include corrections or updates, if any, that may be subsequently made to DFPS data on or after the date this report was prepared.